CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/03/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155625	B. WING		12/08/2011
NAME OF S	DROLUDED OF GUIDELY	D.		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	К	1021 E	CENTRAL AVE	
	GROVE VILLAGE			ISBURG, IN47240	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was for	or a Recertification and	F0000	The creation and submission	n of
		Survey. This visit	10000	this plan of correction does r	
		_		consitute an admission by th	
		restigation of Complaint		provider of any conclusion s	et
	IN00099731.			forth in the statement of	on of
	G1 : (B100	0000721		deficiencies, or of any violati regulation.This provider	OH OI
	Complaint IN00			respectfully requests taht the	
	Unsubstantiated	due to lack of evidence.		2567 Plan of Correction be considered the letter of credi	ible
	Survey dates: D	December 5, 6, 7, and 8,		allegation and requests a de	
	2011			review in lieu of a Post Surve	
				Revisit on or after December	r 28,
	Facility number	. 000305		2011.	
	Provider numbe				
	AIM number: 1				
	7 thivi number.	.00207200			
	Survey team:				
	Penny Marlatt, l	RN-TC			
	Diana Sidell, Ri				
		RN (12-5, 12-7 and 12-8,			
	2011)	10 (12 3, 12 7 and 12 6,			
	2011)				
	Census bed type	·			
	SNF/NF: 70	··			
	Total: 70				
	101.1.70				
	Census payor ty	pe:			
	Medicare: 10				
	Medicaid: 49				
	Other: 11				
	Total: 70				
	Sample: 15				
LARORATOR		WINED CHIDDI IED DEDDECENITATIVE'S SI		דודו ב	(V6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HZJ111

Facility ID:

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MU A. BUII B. WING	LDING	NSTRUCTION 00	(X3) DATE S COMPL 12/08/20	ETED
	ROVIDER OR SUPPLIER		D. WIIN	STREET A 1021 E (DDRESS, CITY, STATE, ZIP CODE CENTRAL AVE SBURG, IN47240		
							715)
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Supplemental sar	mple: 1					
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.						
F0164 SS=D	Williams, RN The resident has t	2/14/11 by Suzanne he right to personal privacy of his or her personal and					
	Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.						
	section, the reside	d in paragraph (e)(3) of this ent may approve or refuse sonal and clinical records to side the facility.					
	personal and clinic when the resident	at to refuse release of cal records does not apply is transferred to another tion; or record release is					
	information contain records, regardles methods, except w transfer to another	eep confidential all ned in the resident's s of the form or storage when release is required by healthcare institution; law; nt contract; or the resident.					
	Based on observa the facility failed confidentiality of	ation and record review,	F0	164	What corrective action(s) will accomplished for those resid found to have been affected the deficient practice? 1. Resident #65 has displayed in	ents by	12/28/2011

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155625	B. WIN	IG		12/08/2	011
NAME OF I	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					CENTRAL AVE		
ARBOR	GROVE VILLAGE			GREEN	ISBURG, IN47240		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ng the healthcare			evidence of being harmed by alleged deficient practice. 2.	the the	
	information of o	ne resident with another			Employee #3 was provided v	vith	
	resident for 1 of	10 residents observed			re-education related to	VIUI	
	during 1 of 4 me	dication passes.			confidentialityHow will you id	entify	
	(Resident #65)				other residents having the	-	
					potential to be affected by the		
	Findings include	•			same deficient practice and		
	l mamgs merade	•			corrective action will be take Residents residing in the fac		
	During a medica	tion pass observation on			have the potential to be affect		
		a.m. with LPN #3, she			by the alleged deficient	, iou	
					practice. 2. Staff re-educate	d on	
		indicate to Resident #66,			the Confidentiality policy and		
	_	ng Resident #65] not			procedure by DNS/ADNS/S		
		the bathroom by herself;			on December 28, 2011.What		
	falls too much ar	nd they just put her on			measures will be put into pla what systemic changes you		
	new medicines, t	too." Resident #66 was			make to ensure that the defic		
	then observed to	indicate, "I didn't know			practice does not recur? 1.		
	that."				will be educated on Confider		
					policy and procedures upon		
	A policy entitled	l, "Confidentiality			and ongoing as needed.2. S	Staff	
		revision date of 1/1999,			will be re-educated on the Conficdentiality policy and		
		the Director of Nursing			procedure by DNS/ADNS/SS	SD on	
		8-11 at 11:51 a.m. This			December 28, 2011. 3.		
		"All internal information			Non-compliance with facility		
	concerning Ame				policy and procedure may re		
					in employee education and/odisciplinary action.4.	or	
		d other corporation or which American Senior			DNS/ADNS/charge nurse wil	I	
					conduct rounds daily to moni		
	Communities pe				communication of staff. 5.		
	information in th				DNS/designee will monitor for		
		st be kept strictly			compliance. How the correct		
		should not be discussed			action(s) will be monitored		
	7 1	inside or outside of			ensure the deficient practic will not recur, i.e., what qua		
	American Senior	r Communities except to			assurance program will be	_	
	the extent necess	sary to perform work for			into place? 1. A Dignity/Priv		
	American Senior	r Communities, nor			CQI tool will be utilized week		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155625 12/08/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1021 E CENTRAL AVE ARBOR GROVE VILLAGE GREENSBURG, IN47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE times four, monthly times two, should such information be discussed and quarterly for one quarter. 2. with any person with American Senior Data will be submitted to the CQI Communities where it could be committee for review. If threshoverheard " hold of 90% is not achieved an action plan may be developed to ensure compliance. 3.1-3(0)3.1-3(p)(2)F0387 The resident must be seen by a physician at least once every 30 days for the first 90 days SS=E after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. What corrective action(s) will be F0387 12/19/2011 Based on interview and record review, the accomplished for those residents facility failed to ensure physician visits found to have been affected by were conducted timely, in that residents the deficient practice? 1. No did not have physician visits every 60 residents were harmed by alleged deficient practice.2. Residents days after the first 90 days. This affected will be seen by December 28, 4 of 13 residents reviewed for timeliness 2011. 3. Medical Records has of physician visits in the sample of 15. utilized Matrix, electronic medical (Residents #25, 45, 48, and 57) record system, by inputting the last physician visit for each individual resident and allowing Findings include: it to generate the next due date for physicians to track each 1. Resident #25's record was reviewed on resident's visits. 4. Medical 12/7/11 at 9:55 a.m. The record indicated Records will update Matrix physician visit tracking on each Resident #25 was admitted with resident with each physician diagnoses that included, but were not visit. 5. Medical Records sent out limited to, diabetes type 2, mild notification of non-compliance to each physician and expectation intellectual disabilities, cataract, renal of facility along with new tracking failure, depression, and anemia. system they will be updated with as needed. How will you identify

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155625			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/08/2	ETED
	PROVIDER OR SUPPLIER	<u> </u>	1	1021 E (DDRESS, CITY, STATE, ZIP CODE CENTRAL AVE SBURG, IN47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	nurse practitione 2/27/11, 3/26/11 6/26/11, 8/1/11, 11/28/11. No documentation indicated the rest the physician. 2. Resident #45' 12/5/11 at 2:50 programmers and paces that in limited to, thyroif fats, dementia, has disease, and paces practitione 2/27/11, 3/26/11 6/26/11, 8/1/11, 11/28/11. No documentation indicated the rest the physician. During an intervent p.m., the Director indicated she contributed in the programmer in the physician.	acluded, but were not ad problems, high blood eart disease, Alzheimer's emaker. The sense indicated the er visited on 1/9/11, 4/23/11, 5/23/11, 9/17/11, 10/23/11, and The sense in the record that ident had been seen by The sense in the record that ident had been seen by The sense in the record that ident had been seen by The sense in the record that ident had been seen by The sense in the record that ident had been seen by The sense in the record that ident had been seen by			other residents having the potential to be affected by the same deficient practice and corrective action will be taken Residents residing in this fact have the potential to be affect by the alleged deficient practice. 2. Medical records personnel will update auditin system in Matrix with every physician visit and notify MD every other Monday of currer due dates. What measures we put into place or what system changes you will make to ensure that the deficient practice does not recur? 1. Medical records personnel will update auditin system in Matrix with every physician visit and notify MD every other Monday of currer due dates. 2. A sign-in book located up at the fron office from signatures of all attending physicians that must be signaprior to treatment to monitor to ensure compliance. 3. Merecords sent out notification non-compliance to each physical expectation of facility allowith the new tracking system they will be updated with as needed. How the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be proposed in the proposed in the physician report every other Monday and send to physician update on next due date. 2. A sign-in book located update on next due date. 2. A sign-in book located up at the fron office from the signatures of all attending physicians that must be signatures of all attending physicians that must be signatures of all attending physicians that must be signatured to each physician that must be signatured to each physician expectation of facility allows the signature of all attending physicians that must be signatured to each physician expectation of facility allows the signature of all attending physicians that must be signatured to each physician expectation of facility and expectation of facility allows the signature of all attending physicians that must be signatured to each physician expectation of facility and the signature of all attending physicians that must be signatured to each physician that must be appl	what n?1. ility sted g s nt ill be nic sure es s g s nt is or ed visits dical of sician ong that will at s ans to	

AND DLANG		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JETIPLE COI	NSTRUCTION	(X3) DATE : COMPL	
AND PLAN U	T CORRECTION	155625	A. BUII		00	12/08/2	
		100020	B. WIN			12/00/2	011
NAME OF PR	OVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARROR G	ROVE VILLAGE				CENTRAL AVE SBURG, IN47240		
		EATEMENT OF DEFICIENCIES		<u> </u>		1	OVE.
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	3. Resident #48's reviewed on 12-6 diagnoses include to, senile dement psychosis, Alzhe blood pressure, tr (TIA's or mini-str depression. Review of the ph September 2010 care physician has 9-25-10, 1-15-11 This indicated a l time period 9-25-147 days for the treatment of the current formula of the current line an interview with Nursing Services she indicated, "Woother doctor's vis	s clinical record was 5-11 at 10:17 a.m. Her ed, but were not limited ia, dementia with imer's disease, high ransient ischemic attacks rokes), anxiety and ysician visits since indicated the primary ad documented visits on , 6-11-11 and 9-10-11. lapse of 112 days for the -10 to 1-15-11; a lapse of time period 1-15-11 to of 91 days for the time of 9-10-11 and a lapse of me period 9-10-11 to the at chart review. With the Director of on 12-6-11 at 3:50 p.m., We could not find any its other than what you t. We have a new person		TAG	physician Services CQI tool of be completed weekly for four weeks, monthly for two months and quarterly for one quarter Data will be submitted to the committee for review. If three of 90% is not achieved, an applan may be developed to encompliance.	will hs, .3. CQI shold ction	DATE

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00		COMPL	
		155625	B. WI				12/08/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STA	TE, ZIP CODE		
					CENTRAL AVE	10		
	GROVE VILLAGE				SBURG, IN4724	łU		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ΓE	COMPLETION
TAG		the MD's [destaris]	-	TAG	DEFF			DATE
		the MD's [doctor's]						
	visits."							
	4 771 . 11 1 1							
	4. The clinical record of Resident #57's							
	was reviewed on 12-7-11 at 11:45 a.m.							
		ncluded, but were not						
		ntellectual disabilities,						
		ipolar disorder, diabetes,						
		sure, osteoarthritis, and						
	gastroesophagea	ıl reflux disease.						
	Review of the att	ttending physician's visits						
	for the time perio	od November 2010 to the						
	date of the clinic	cal record review						
	indicated there w	were no visits by the						
	attending physic	eian. This indicated a lack						
	• • • •	e attending physician for						
	one year.	51 5 1 1						
	- 5							
	The clinical reco	ord review indicated a						
		er had conducted visits on						
		, 3-26-11, 4-23-11,						
		1, 8-1-11, 9-17-11,						
	10-23-11 and 11-							
		of the nurse practitioner						
		1, 3-26-11, 4-23-11,						
		6-11 indicated the						
	physician had ini							
	practitioner visit	t form.						
		id d Di i						
		with the Director of						
		s (DNS) on 12-8-11 at						
		indicated, "I could not						
	find any other do	octor visits for [name of						
FORM CMS-2	567(02-99) Previous Version	ions Obsolete Event ID:	HZJ111	Facility I	D: 000305	If continuation sh	neet Pa	ge 7 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CON	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155625	B. WING	i		12/08/2	U11
NAME OF P	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					CENTRAL AVE		
ARBOR (GROVE VILLAGE			GREENS	SBURG, IN47240		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	her than the nurse					
	practitioner visits	s that he initialed."					
	Services" was pro- Health Services of The policy include to, "Policy: A quality supervises the her resident. Procedure physician visits a (30) days for the after admission, a thereafter. A phy- timely if it occurs	2 2					
F0388 SS=D	(f) of this section, a must be made by the made by the made by the must be made by the must be made by the must be made between personal visits by a physicial practitioner or clinical accordance with pure must be made all visits were made all visits were made all visits were made must be made all visits were made all visit	cal nurse specialist in aragraph (e) of this section. ew and record review, the ensure required physician by the physician in that	F03	388	What corrective action(s) will accomplished for those resid found to have been affected the deficient practice?1. No residents were harmed by all deficient practice.2. Residen	ents by eged	12/19/2011

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL	
ANDILAN	OF CORRECTION	155625		LDING		12/08/2	
		100020	B. WIN			12/00/2	011
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE		
ARBOR	GROVE VILLAGE				SBURG, IN47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\top	ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
	physician. This	affected 3 of 13 residents			will be seen by December 28		
	reviewed for phy	ysician visits in a sample			2011.3. Medical Records se		
	of 15. (Resident	ts #25, #45, and #57)			out notification of non-compli		
	or restriction was, with the restriction				to each physician and expectations of facility along	with	
	Findings include	•			new tracking system they wil		
	i mamga marada	•			updated with as needed.4.		
	1 Resident #25	's record was reviewed on			Medical records personnel w		
		a.m. The record indicated			audit all physician visits/NP v		
	Resident #25 wa				every 2 weeks and notify MD as needed. How will you iden		
					other residents having the	шу	
		acluded, but were not			potential to be affected by the	е	
	limited to, diabet	• •			same deficient practice and v		
		pilities, cataract, renal			corrective action will be taken		
	failure, depression	on, and anemia.			Residents residing in this fac		
					have the potential to be affect by the alleged deficient	tlea	
	Physician's prog	ress notes indicated the			practice.2. Medical records	will	
	nurse practitione	er visited on 1/9/11,			monitor for accuracy.What		
	2/27/11, 3/26/11	, 4/23/11, 5/23/11,			measures will be put into pla		
	6/26/11, 8/1/11,	9/17/11, 10/23/11, and			what systemic changes you		
	11/28/11.				make to ensure that the defice practice does not recur?1.	cient	
					Medical Records personnel v	will	
	A physician's vis	sit was due on 3/26/11			monitor NP/MD visits and no		
	and 8/1/11.				physicians every 2 weeks of		
					expectations and next visit		
	No documentation	on was in the record that			needs.2. DNS/designee will monitor for compliance.How	the	
		ident had been seen by			corrective action(s) will be		
	the physician.	- u			monitored to ensure the defic	cient	
	life physician.				practice will not recur, i.e., w		
	2 Resident #45'	's record was reviewed on			quality assurance program w		
		o.m. The record indicated			put into place?1. Medical red personnel will run Matrix	coras	
	Resident #45 wa				physician report every other		
					Monday and send to physicia	ans to	
	_	icluded, but were not			update on next due date.2.		
	1	id problems, high blood			Medical Records will monitor		
		eart disease, Alzheimer's			NP/MD visit rotations every t		
	disease, and pace	emaker.			weeks.3. A Physician Service	es	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE COMPL	
THE TEAM	o. conduction	155625	A. BUI B. WIN	LDING		12/08/2	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			CENTRAL AVE		
ARBOR	GROVE VILLAGE			GREEN	SBURG, IN47240		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
					CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	
(X4) ID PREFIX TAG	Physician's prograurse practitione 2/27/11, 3/26/11 6/26/11, 8/1/11, 11/28/11. A physician's visuand 8/1/11. No documentation indicated the rest the physician. During an intervent p.m., the Director indicated she condocumentation the been in to see this 3. The clinical rewas reviewed on Her diagnoses in limited to mild in schizophrenia, behigh blood press gastroesophagea. Review of the att for the time period date of the clinical restrictions.	ress notes indicated the revisited on 1/9/11, 4/23/11, 5/23/11, 9/17/11, 10/23/11, and sit was due on 3/26/11 on was in the record that ident had been seen by iew on 12/6/11 at 4:45 or of Health Services ald not find any hat said the physician had is resident. ecord of Resident #57's 12-7-11 at 11:45 a.m. included, but were not intellectual disabilities, ipolar disorder, diabetes, ure, osteoarthritis, and 1 reflux disease. tending physician's visits and November 2010 to the		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	eekly vo e d to v. If	(X5) COMPLETION DATE
	attending physic	ian. This indicated one					
	-	ts from the attending					
	physician.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155625		ĺ	LDING	NSTRUCTION 00	(X3) DATE (COMPL 12/08/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER		_		DDRESS, CITY, STATE, ZIP CODE		
	GROVE VILLAGE				CENTRAL AVE SBURG, IN47240		
				<u> </u>	3BURG, IN47240		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	nurse practitione 1-9-11, 2-27-11, 5-23-11, 6-26-11 10-23-11 and 11 documentation or visits on 2-27-11 5-23-11 and 6-26 physician had interpractitioner visit. In an interview or Nursing Services 11:21 a.m., she is find any other documentationer visit. A policy and professioner visit. The policy include to, "Policy: A quality supervises the heresident. Proceed physician visits at (30) days for the after admission, thereafter The pubetween personal	f the nurse practitioner, 3-26-11, 4-23-11, 6-11 indicated the itialed the nurse form. with the Director of (DNS) on 12-8-11 at indicated, "I could not octor visits for [name of the than the nurse is that he initialed." Incedure for "Physician ovided by the Director of con 12/7/11 at 9:15 a.m. ded, but was not limited italified physician ealthcare of every ureThe attending at least once every thirty first ninety (90) days and at least every 60 days obysician may alternate I visits and visits by a int, or nurse practitioner					

STATEMEN		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155625	B. WING	3		12/08/2	011
	ROVIDER OR SUPPLIER			1021 E	.DDRESS, CITY, STATE, ZIP CODE CENTRAL AVE SBURG, IN47240		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3.1-22(d)(3)						
	3.1-22(d)(4)						
	3.1-22(f)(1)						
	3.1-22(f)(2)						
F0425 SS=E	The facility must pemergency drugs residents, or obtain described in §483. facility may permit administer drugs if under the general nurse. A facility must proviservices (including accurate acquiring administering of all meet the needs of The facility must e of a licensed pharmonistering of all pharmacy services. Based on observate record review, the accurate administer administerior medication prior medication. This	and biologicals to its in them under an agreement in the unlicensed personnel to its State law permits, but only its supervision of a licensed wide pharmaceutical ity procedures that assure the ity, receiving, dispensing, and it drugs and biologicals) to each resident. In the facility of the provision of its in the facility, ation, interview, and ity failed to ensure inistration of medication, ininistration of eye drops on of administration of ito administering the ity affected 4 of 10	F0-	425	What corrective action(s) will accomplished for those resid found to have been affected the deficient practice?1. Res #57 was not harmed by alleg deficient practice.2. Employe was provided with re-educatirelated to accuracy of eye dradministration.3. Employees	ents by sident ed ee #1 on op	12/28/2011
	residents observe medication passe and 57) Findings include	es. (Residents #A, 49, 53,			was provided with re-educating related to signing off the MAF prior to administration.4. State are now waiting the appropriate 5 minutes between eye drops.5. Medications are administered prior to initialing MAR. How will you identify other than the manufacture of the manufacture	R ff ate 3 g in	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **HZJ111** Facility ID:

000305

If continuation sheet

Page 12 of 21

PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1. During a medication administration observation on 12/7/11 beginning at 8:52	Y
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1. During a medication administration observation on 12/7/11 beginning at 8:52	
observation on 12/7/11 beginning at 8:52 be affected by the same deficient	(X5) PLETION ATE
a.m., LPN #5 was observed as she prepared medications for Resident A. LPN #5 prepared II medications for Resident A. LPN #5 prepared II medications for Resident #A and initialed the medication administration record (MAR) before administration record in the medication administration observation on 12/8/11 at 8:25 a.m., RN #2 was observed as she prepared medications for Resident #49. RN #2 prepared 5 medications for Resident #49 and initialed the medications as given on the MAR before administering the medications off as she goes to keep track of what she's got. RN #2 then prepared one "as needed" medication agiven prior to administration and prepared II medications for Resident #A and initialed the medications for Resident #A and initialed the medications of Resident #A and initialed the medications of Resident #A and initialed the medications for Resident #A and initialed the medica	

Facility ID:

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	A. BUII	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/08/2011		
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			D. WIN	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN47240				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPL		
TAG	3. During a med on 12-5-11 at 4:3 was observed to Artificial Tears i #57 at 4:42 p.m. was then observe of Patanol 0.1% each eye of Resident #57's re 12/07/11 at 11:4: physician orders indicated Artific Solution, adminifour times daily 0.1% Opthalmic drop in each eye breakfast and be: In interview with 4:49 p.m., she in least one minute A policy for "Me Procedure", with 2/2011, was prove Nursing Services 12:17 p.m. The not limited to: "will be recorded Administration Ferrored to the service of t	dication pass observation 38 p.m. with LPN #1, she administer one drop of into each eye of Resident At 4:44 p.m., LPN #1 ed to administer one drop Ophthalmic Solution into dent #57. This indicated minutes between the ops. ecord was reviewed on 5 a.m. The current for Resident #57 ial Tears Opthalmic ister one drop in each eye and indicated Patanol Solution, administer one twice daily, before fore supper. In LPN #1 on 12-5-11 at indicated, "We're to wait at between eye drops." The indicated Patanol is in the indicated is in the indicated is in the indicated in the indicated is in the indicated		TAG	assurance program will be pinto place?1. DNA/designed utilize a Medication Adminis sklls validation tool three tim week for two weeks and one month for six months.2. Pharmacy consultant will austaff for proper medication administration monthly for simonths.3. Results of skills validation tools and pharmac consultant audit will be report to the CQI committee on a monthly basis for six months any errors found will develop action plan.5. DNS/designer review audits and initiate action plan as needed.	ut e will tration es a ee a dit x cy rted s.4. If o an e will	TE .	
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	HZJ111	Facility I	D: 000305 If continuation s	heet Page 14 of	f 21	

PRINTED: 01/03/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	ie survey ipleted 3/2011
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			1021 E	ADDRESS, CITY, STATE, ZIP O CENTRAL AVE ISBURG, IN47240	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	-	olicy also indicated, separated 3-5 minutes to corption."				
	"Instilling Eye D DNS on 12-7-11 activation date o "Waits [sic] 1 m	er procedure, entitled, Drop(s)," provided by the at 12:17 p.m. with an f 2/2010, indicated, inute between drops and en different drops."				

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 12/08/20	ETED	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE				1021 E	.ddress, city, state, zip code CENTRAL AVE SBURG, IN47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ.	(X5) COMPLETION DATE
F0441 SS=D	The facility must el Infection Control F a safe, sanitary ar and to help preventransmission of discontrol for the facility must el Program under who (1) Investigates, confections in the facility must elegate the facility must isolate the facility must	stablish and maintain an Program designed to provide and comfortable environment and the development and sease and infection. of Program stablish an Infection Control which it - controls, and prevents cility; procedures, such as a applied to an individual exercity of incidents and related to infections. The add of Infection control Program resident needs isolation to do of infection, the facility					
	(c) Linens Personnel must he transport linens so infection. Based on observe record review, the routine and approwashing and glo	andle, store, process and as to prevent the spread of ation, interview and a facility failed to ensure opriate use of hand	F0	441	What corrective action(s) will accomplished for those reside found to have been affected the deficient practice?1. Residents #47 and #A were harmed by alleged deficient	dents by	12/28/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155625 12/08/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1021 E CENTRAL AVE ARBOR GROVE VILLAGE GREENSBURG, IN47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE practice.2. Employee #4 and change with a gastrostomy tube, then Employee #5 were provided with received a gastrostomy medication re-education related to hand administration and then received oral washing.3. Staff now utilizing hygiene. proper hand washing techniques per facility policy. How will you - with dispensing of medication from a identify other residents having the bubble packaging system into a staff potential to be affected by the member's bare hand prior to same deficient practice and what administration to a resident. corrective action will be taken?1. - with care involving opening of sterile Residents residing in the facility have the potential to be affected packaging to be used in the suctioning of by the alleged deficient a resident with a tracheostomy. practice.2. DNS/ADNS These deficient practices affected 3 of 10 re-educated staff on Infection residents observed during 2 of 4 Control/Hand washing on December 28 2011.What medication passes. (Residents #47, #40, measures will be put into place or and #A) what systemic changes will you make to ensure that the deficient Findings include: practice does not recur?1. Staff educated on hand washing policy and procedures upon hire and 1. During a medication pass observation ongoing as needed.2. on 12-5-11 at 4:17 p.m., LPN #1 was Non-compliance with facility observed to remove a dressing from policy and procedure may result in employee education and/or around Resident #47's gastrostomy tube disciplinary action.3. Hand with gloved hands and then cleanse the washing skills validation will be area with a gauze pad moistened with tap utilized for check offs on all staff water. She then proceeded to open a at the inservice on December 28. 2011.4. DNS/ADNS/designee will sterile package of a dressing and then conduct rounds on a daily basis placed it around the GT site without to ensure appropriate hand washing her hands or changing gloves. washing/infection control She then continued care to Resident #47 techniques.5. DNS/designee will monitor for compliance. How the by removing the gloves and without corrective action(s) will be washing or sanitizing her hands to prepare monitored to ensure the deficient and administer 10 milliliters of Abilify practice will not recur, i.e., what liquid (1 milligram per milliliter strength) quality assurance program will be put into place?1. An infection for a total of 10 milligrams of the Facility ID: HZJ111

AND PLAN OF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/08/2	ETED
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			•	1021 E	DDRESS, CITY, STATE, ZIP CODE CENTRAL AVE SBURG, IN47240		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
si o g	he removed the por sanitizing her bloves, she proce	er completing this task, gloves. Without washing hands or putting on eded to administer oral sident with moistened			Control CQI tool will be utilize weekly times four, monthly til two, and quarterly for on quarter.2. Data will be submet to the CQI committee for revisit threshhold of 95% is not achieved an action plan may developed to ensure compliant.	me itted iew. be	
0 0 3 6 fi p n	on 12-7-11 at 8:2 observed to dispendent to dispendent to dispendent to milligram to the following these medication cup for interview with						
n ii	ot supposed to p	oop them [medications] ut some of the packaging					
o w E	on 12-7-11 at 8:5 was also being of Director of Nursi observed to admire atment to Resi observed at 9:13 hebulizer tubing without washing or the use of glownedication into the second of the second o	ication pass observation 2 a.m., LPN #5, who be be be the Assistant ing Services, was inister a breathing dent #A. She was a.m. to obtain the from a plastic bag or sanitizing her hands res to place the the nebulizer cup. At 5 had obtained several					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/08/2	ETED
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			•	1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE SBURG, IN47240	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	#A's tracheostom resident. At this her hands after c treatment, she stapackage of a suc LPN #5 was stop she laid the steril she began to ope LPN #5 then was resumed opening to suction the resident's oxy throughout the n treatment. A policy entitled activation date o by the Director of (DNS) on 12-7-1 policy indicated, single most importransmission of i workers shall was and appropriately shall wash hands /serving meals, detcBefore/after contact with residents.						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155625		A. BUI	LDING	NSTRUCTION 00	l i	E SURVEY PLETED 2011	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			B. WIN	1021 E	DDRESS, CITY, STATE, ZIP CO CENTRAL AVE SBURG, IN47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	specimens, resided A policy entitled Precautions," with 7/2008 was provided 12-8-11 at 11:51 indicated, "Wear reasonably anticining contact with mon-intact skin, a substance OR sure Change gloves be are not a cure-all likelihood of congloves are worse microorganisms than to the skin, handle medical econtaminated globetween different body sites of the A procedure entity Medication Administration was application of gloves, follow A procedure entity of gloves are well as a procedure entity of gloves.	ent equipment" , "Implementing Standard th an activation date of ided by the DNS on a.m. This policy gloves when it can be spated that hands will be nucous membranes, and/or moist body rfaces soiled by them. etween residentsGloves Gloves reduce the staminating handsDirty than dirty hands adhere to the glove better HCW MUST NOT equipment, devices with ovesChange gloves t residents, or different same resident." tled, "Enteral Tube sinistration," with an f 2/2010 was provided by 1-11 at 12:17 p.m. This to begin the medication ith handwashing and oves and to end the mistration with removal red by handwashing.					DATE
	- I racheostomy T	Tube," with an activation					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/08/2	ETED
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE			•	1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE SBURG, IN47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	on 12-8-11 at 11 indicated to begin handwashing and and to end the property of	as provided by the DNS :51 a.m. This policy n the procedure with d application of gloves ocedure with removal of by handwashing.					